APPENDIX A

ATTESTATION OF SURGICAL MEMBER OF AN AMERICAN CLEFT PALATE-CRANIO-FACIAL ASSOCIATION APPROVED TEAM

I,	, am a Member of
NAME	NAME OF
ORGANIZATION the American Cleft Palate-Craniofacial	, a cleft-craniofacial team approved by Association.
On, 20, I exa	minedand PATIENT NAME Iddition, I examined the proposed treatment plan
and treatment plan accompany this doc	. Copies of the medical records rument.
suffers from craniofacial anomaly. I fu	PATIENT'S LAST NAME rther attest that the proposed treatment plan will re medically necessary to improve a functional acial anomaly.
SIGNATURE	
PRINTED NAME	
DATE	